Wisconsin Department of Regulation & Licensing

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DENTISTRY EXAMINING BOARD

CERTIFICATION OF INFERIOR ALVEOLAR INJECTION

To be completed by supervising dentist if injection completed outside of coursework

NAME OF APPLICANT: (Please print) _____

I _____ certify that while under my supervision _____
(Name of employing dentist) (Name of dental hygienist)

successfully completed an inferior alveolar injection on _____
(Name of non-classmate patient)

who was informed of the procedure and granted his/her consent to the dentist.

The inferior alveolar injection was completed within six (6) weeks from the time that the licensed dental hygienist completed his/her coursework; or within 6 weeks of becoming licensed as a dental hygienist in the state of Wisconsin if licensed by endorsement from another state.

_____ _____
Signature and Title Name of Practice

_____ _____
Print Name and Wisconsin Dental License Number Street Address

( ) _____ _____
(Daytime phone number) City and State Zip Code

_____
Date

#2458 (Rev. 2/03)
Ch. 447, Stats.